



Texas Department of Insurance

Division of Workers' Comp

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS HEALTH SYSTEM
3255 WEST PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name

PHARR SAN JUAN ALAMO I S D

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-10-1730-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by South Texas Hospital to audit their Workers Compensation claims. We have found in the audit they have not paid what we determine to be 'fair and reasonable' amount for this outpatient surgery." "Per the applicable Texas fee schedule the correct allowable would be per the DRG 473. The allowable for this DRG per Medicare is \$16,196.51, we have also attached the print out for your review from the Medicare pricer program. The correct allowable would be at 143% making the allowable at \$23,161.00. Based on their payment of \$15,738.53, there is an additional of \$7,442.47, still due at this time." **"We also verified there was no PPO reduction taken, and that the incorrect DRG was used in the pricing of this claim. We submitted a reconsideration to get a resolution prior to filing this dispute but the carrier is staying with their original allowance."**

Amount in Dispute: \$7,442.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider billed the Carrier \$119,084.75 for the above dates of service related to an in-patient hospital stay. The Carrier reimbursed the Provider \$15,738.53 as evidenced by the enclosed EOB. The Provider is requesting further reimbursement in the amount of \$7442.47, alleging that the MAR for the services rendered is \$23,161.00. Carrier contends that reimbursement in the above case has been calculated correctly per the in-patient hospital fee guidelines, and no further reimbursement is owed."

Response Submitted by: Parker & Associates, LLC, 7600 Chevy Chase Dr., Suite 350, Austin, Texas 78752

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 9, 2009 through March 12, 2009	Inpatient Hospital Surgical Services	\$7,442.47	\$7,438.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
 - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
 - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
 - (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
 - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 143 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated April 20, 2009

 - 45 –CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. (USE GROUP CODES PR OR CO DEPENDING UPON LIABILITY).
 - W1 –WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.

Explanation of benefits dated October 15, 2009

 - W3 –ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
3. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The respondent denied reimbursement for the disputed service based upon "45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement." 28 TAC §133.3 requires that "Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the respondent to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as 'insurance carrier improperly reduced the bill' or 'health care provider did not document' or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section." The Division finds that the denial reason is generic because it does not identify

where a contract was accessed, nor does it identify the network if indeed a discount was taken due to a contract. On November 3, 2010 the Division requested a copy of the contract between the network and the health care provider. The carrier responded stating, "Please be advised no PPO contract reduction was taken." Therefore, the Division concludes that the disputed services are not included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011.

2. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
3. Review of the submitted documentation finds no request for separate reimbursement of implantables in accordance with 28 Texas Administrative Code §134.404(g).
4. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows:

The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 473 is \$16,207.71.

This amount multiplied by 143% is \$23,177.03.

The total maximum allowable reimbursement (MAR) is \$23,177.03.

This amount less the amount previously paid by the respondent of \$15,738.53 leaves an amount due to the requestor of \$7,438.50.

The Division concludes that the requestor is entitled to \$7,438.50 additional reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$7,438.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$7,438.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	September 19, 2011 Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.